VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 25, 2012

Mr. James Beeler, Administrator
Rowan Court Health & Rehab
378 Prospect Street
Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 9, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWAN COURT HEALTH & REHAB	378 PROSPECT STREET BARRE, VT 05641

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F 000	INITIAL COMMENTS An unannounced, on site, annual re-certification survey was conducted by the Division of Licensing and Protection from 05/07/2012 through 05/09/2012. The following regulatory deficiencies were identified.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 **No Residents were harmed by this alleged deficient practice.** Resident #49 no longer resides at the center. All residents have the potential to be affected by this alleged deficient practice. practice. practice. Nurses will be reeducated on the policy and procedure for reporting requirements for all changes in conditions. All resident changes in condition will be reviewed at concurrent review to monitor for nurse compliance. The results of all reviews will be reported to QI Committee monthly x 3 months. DNS or designee will be responsible for compliance. Completion date June 9, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/31/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

→ Revised and resubmitted on 6/8/2012

PMC

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that the physician and family were notified of a significant change in medical symptoms after a fall for one of three applicable resident in the targeted sample. (Resident #49) Findings include: Per closed record review on 5/9/12, Resident #49 experienced a significant change in medical symptoms after four unwitnessed falls within 48 hours and staff failed to notify the physician and family. A progress note dated 2/2/12 at 0845 stated "nurse took over medication care at 0650 and was notified in report that pt. had fallen out of bed at 0600....pt... awake most of night and may be sleepy. Pt....difficult to arouse, pupil response was sluggish, right hand grasp slightly greater than left, patient could not follow command to move legs, patient gave minimal response to sternal rub. This nurse attempted to asses vital signs and could not obtain B/P (blood pressure) reading from automatic cuff in left wrist.... Unit Manager able to obtain B/P in left arm using manual cuff. Vital signs were assessed two times on neurological assessment form, at 0705 and 0720, before patient left to be transferred to new facility. Patient vomited one time, clear liquid emesis, this was not alarming as this manifestation was consistent with 24 hour "bug" that has affected staff and residents over past 2 weeks." The nurse author of this note was interviewed on	F 157	F157 POC accepted 6/14/12 TMynhierRN/DMcotaRN	

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F 157	Continued From page 2 5/9/12 at 2 PM and she confirmed that she did not notify the physician and family of the change in symptoms and multiple falls prior to discharge at approximately 8:45 A.M. on 02/02/12. Although a staff member accompanied the Resident on the van ride (a 2+ hour ride) to the new facility, the nurse could not be sure that the Resident was not exhibiting symptoms of possible significant head or other injury just prior to discharge. Refer also to F323	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview the facility failed to ensure that one unsampled Resident was able to make choices about aspects of his/her life in the facility that are significant to the resident. This affected one Resident (#68) observed dining in the facility main dining room during the initial dining observations. The findings include: 1. Per observation on 5/07/12 at 12:00 P.M., in the main dining room, Resident #68 was provided a meal at 12:15 P.M. Resident #68 was observed taking a couple bites from the plate that	F 242		

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F 242	Continued From page 3 contained steamed broccoli, scalloped potatoes and ground chicken. Resident #68 was observed for approximately 30 minutes not eating anything further from his/her plate. At 12:45 P.M., Resident #68 verbalized during interview, that he/she did not like the meal and did not feel it was appetizing. Resident #68 indicated he/she wanted something else. During the observation from 12:15 P.M. to 12:45 P.M., there were two staff members present in the dining room and at no time during the observation did they approach Resident #68 to inquire why he/she was not eating the meal. At 12:45 P.M., a Geriatric Aide (GA) removed Resident #68's plate from the table and discarded the uneaten meal in the trash. It was observed that the GA did not inquire why the resident had not consumed his/her meal and no alternative choices were offered. Per interview with the GA at approximately 12:50 P.M., he/she confirmed that he/she did not inquire why the meal had not been consumed and confirmed that he/she did not offer any alternative to Resident #68. Per interview with the Licensed Nursing Assistant Team Leader at approximately 12:50 P.M., he/she indicated that no alternative was offered to Resident #68 and that the expectation is that if a resident is noted to not be eating their meal an inquiry should be made as to why and an alternative offering be made. Per interview with the Dietary Manager (DM) on 5/9/12, he/she indicated that alternative food offerings are placed on the steam table for each meal and these alternatives are to be offered to residents that choose not to eat the main meal offering. The DM also confirmed that the facility will provide other alternatives not on the steam table upon request to ensure each resident	F 242	F 242 **No Residents were harmed by this alleged deficient practice.** Resident #68 was not affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. Nursing staff will be reeducated on the procedure for offering alternate meal choices and availability of the meal choices. Meal service will be audited 5 x / week and x 90 days. The results of all audits will be reported to QI Committee monthly. DNS or designee will be responsible for compliance. Completion date: June 9, 2012 F242 POC accepted 6/14/12 TMyhre RN QI Nurse RN	

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F 242	Continued From page 4 receives a meal the resident will consume. The DM also confirmed that staff members are to offer alternatives when residents do not consume the offered meal.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based clinical record review and interview, the facility failed to ensure that one Resident received the assistance necessary to be up and dressed prior to 7:00 A.M., on two of three days of the survey, per the Resident's stated preference. This affected one (#19) of 19 Stage 2 sampled Residents. Findings include: During interview on 05/08/12 at 8:48 A.M., Resident #19 stated a preference to be up and dressed very early in the morning. Resident #19 went on to state that staff had not been providing the assistance needed with this task for several mornings. Resident #19 stated that often the staff would set up supplies for the Resident to begin dressing and would not come back to provide assistance for a long time, requiring the Resident to wait partially dressed until they returned. The Resident stated that for several mornings dressing assistance had not been	F 246	F 246 **No Residents were harmed by this alleged deficient practice.** Resident #19 was not affected by this alleged deficient practice. The resident will be encouraged to get dressed on a daily basis. When resident agrees to get dressed, assistance will be provided as needed. Any resident who has dressing choices has the potential to be affected by this alleged deficient practice. practice. practice. Staff will be educated on offering dressing assistance to residents. Any refusals will be reported to the Charge Nurse and documented in the medical record. The care plan will be updated.	

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F 246	Continued From page 5 provided until late in the morning. Interview of the Licensed Nurse Aid (LNA) assigned to care for Resident #19 on first shift on 05/08/12 at 10:55 A.M. revealed that the LNA had the same assignment on 05/07/12 and 05/08/12. The LNA stated that the night shift staff was supposed to get four or five people up before leaving at 7:00 A.M. The LNA verified that Resident #19 wanted to be up and dressed very early and was on the list of Residents that night shift was assigned to get up. The LNA stated that on both days, 05/07/12 and 05/08/12, Resident #19 was not up and dressed and the first shift staff assisted the Resident later in the morning. The LNA stated the Resident had complained that the previous shift did not provide the assistance required on those mornings. Interview of the Registered Nurse, Unit Manager on 5/9/12 at approximately 11:00 A.M., confirmed that the night shift was assigned to get Resident #19 up and dressed prior to 7:00 A.M. per the Resident's preference. The RN stated that the night shift was staffed with one charge nurse and two LNA's and the staffing pattern had not changed. The RN claimed no knowledge of the Resident refusing to get up in the morning and was unable to locate documentation of any reason the night shift staff had not assisted the Resident.	F 246	Residents will be checked during AM rounds for compliance with resident dressing preference, x 30 days. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F246 POC accepted 6/14/12 TMynhier RN | CMcotoRN	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		

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F 272	Continued From page 6 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to periodically conduct accurate and on-going assessments for two of 19 residents in the applicable sample (Residents #	F 272	F 272 **No Residents were harmed by this alleged deficient practice.** Residents #17 and #87 were not affected by this alleged deficient practice. Resident #17 side rail assessment has been completed. The resident no longer requires side rails. Assessments for resident #87 for the following were completed: Bowel Skin Bladder assessments Care needs related to CVC. All residents requiring assessments have the potential to be affected by this alleged deficient practice.	

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F 272	Continued From page 7 17 and # 87). Findings include; 1. Per record review on 5/8/12, there was no current side rail assessment for Resident # 17 who has fallen 10 times since admission to the facility. Per interview with the Wing 2 Unit Manager (UM) on 5/8/12 at 4:55 P.M., side rail assessments are to be done quarterly and as needed. The UM confirmed that the last side rail assessment had been done 1/9/12 and the assessment due in April 2012 had not been done. 2. Per record review on 5/8/12, Resident # 87 had multiple needs including bowel incontinence, recurrent skin breakdown on the buttock area, a Foley catheter with no diagnosis or reason for use and a central venous catheter (CVC) for access for dialysis; there was no evidence in the medical record of accurate and on-going assessments to address these needs. During interview with the Unit Manager on 5/8/12 at 4:35 P.M., s/he confirmed that s/he had not assessed the Resident's bowel incontinence. Regarding the Foley catheter, a progress note written by the Nurse Practitioner dated 6/27/11 stated "Foley placed in hospital, goal is to remove after PU (pressure ulcer) heals and likely do bladder retraining." During interview at 4:25 P.M., on 5/8/12, the Unit Manager confirmed that she had not been aware of a diagnosis or reason for the use of the Foley catheter and had not completed a bladder assessment. S/he also confirmed that there was no assessment to determine the possible cause of the bowel incontinence, nor was there any assessment of the care needs related to the presence of the CVC for dialysis. Refer also to F315 and F309	F 272	Audits of residents assessments will be completed. Nurses will be reeducated on the assessment requirement for residents. Assessments will be audited weekly x 60 days. The results of all audits will be reported to the QI Committee monthly x 3 months. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F272 POC accepted 6/14/12 TMyhrer RN/ DMcotarn	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure that the care plan for one of 19 residents in the applicable sample addressed all of the identified needs and included measurable goals and specific interventions to address these needs. (Resident # 87) Findings include: Per record review on 5/8/12, Resident #87 received dialysis treatments three times weekly via a central venous catheter (CVC) access, had bowel incontinence one to three times weekly and	F 279	F 279 **No Residents were harmed by this alleged deficient practice.** Resident #87's care plan have been updated to address all specific needs and new specific interventions to meet these needs. Any resident with dialysis via CVC, bowel incontinence or specific dietary needs related to dialysis has the potential to be affected by this alleged deficient practice. The care plan of all residents who have dialysis and/or bowel incontinence will be audited for the proper care plan development, including goals and specific intervention. Dietary assessments of dialysis residents will be audited for compliance including goals and concerns.	

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F 279	Continued From page 9 recurrent skin breakdown on the buttocks. Per review of the care plan for dialysis, the plan incorrectly identified the type of access being used, included inappropriate interventions not related to the Resident's needs, lacked appropriate goals for nutrition regarding dialysis and related dietary concerns and failed to include any interventions related to the presence of the CVC and it's impact on care received in the nursing home. Refer also to F309. The care plan for bowel incontinence had no goal and lacked specific interventions to improve bowel continence and functional abilities. During interview on 5/8/12 at 4:25 P.M., the Unit Manager confirmed that the care plan for dialysis was not accurate nor complete, failed to address the CVC and related needs and included inappropriate interventions that did not apply to the Resident's circumstances. S/he also confirmed that there was no goal for bowel incontinence nor specific interventions to address this need. Refer also to F315	F 279	The results of all audits will be reported to the QI Committee monthly. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F279 POC accepted 6/14/12 TMynhierRN/DMcotaRN	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F 280 **No Residents were harmed by this alleged deficient practice.** Resident #55 was not affected by this alleged deficient practice. This resident care plan has been updated to reflect the removal of the side rails.	

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F 280	Continued From page 10 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan for one of 19 residents in the stage 2 sample (Resident # 55). Findings include; Per observation on 5/9/12 at 12:59 P.M., Resident # 55 was lying in bed with no side rails on the bed. Per review of the care plan for Resident # 55 on 5/9/12, the care plan interventions included bilateral 1/2 side rails to assist with bed mobility. A side rail assessment dated 1/2/12 indicated Resident # 55 has bilateral 1/2 side rails to assist with independent bed mobility. The Unit Manager confirmed at 1:10 P.M. on 5/9/12 that side ralls had been removed from the bed and that the care plan had not been revised to reflect this change.	F 280	Any resident with side rails have the potential to be affected by this alleged deficient practice. All resident's side rail documentation will be audited to insure an assessment and compliance with assessments. Random audits will be done weekly x 60 days. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F280 POC accepted 6/14/12 TMyhrer RN/ DNecotaRN	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282	F 282 **No Residents were harmed by this alleged deficient practice.** Resident #17 was not affected by alleged deficient practice.	

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F 282	Continued From page 11 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement the care plan for one of 19 residents in the stage 2 sample (Resident # 17). Findings include: Per observation of Resident # 17's room on 5/8/12 at 4:02 PM, there were bilateral 1/2 side rails in the raised position on the resident's bed. At the time of the observation, the Unit Manager (UM) confirmed that the side rails were in raised position on the bed and that both the plan of care and the Licensed Nursing Assistant's plan of care stated that there was to be no side rails on Resident # 55's bed. The record contained a physician order dated 2/6/12 to discontinue the use of side rails.	F 282	The side rails were removed per MD order. All residents utilizing side rails has the potential to be affected by this alleged deficient practice. All MD orders for side rails will be audited and visual observation made to insure compliance with MD order. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F282 POC accepted 6/14/12 TMynhierRN/ DMcotaRN	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, nursing staff failed to provide the necessary care and services to maintain the	F 309	F 309 **No Residents were harmed by this alleged deficient practice.** Resident #87 was not affected by this alleged deficient practice. The assessment was completed. Any resident has the potential to be affected by this alleged deficient practice.	

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F 309	Continued From page 12 highest practicable physical and psychosocial needs for 1 of 2 applicable residents in the targeted sample. (Resident #87) Findings include: Per record review, and resident and staff interview, staff failed to complete accurate and thorough assessments and plans of care for Resident #87, who was receiving outpatient dialysis treatments and who also experienced recurrent impaired skin integrity due to issues related to bowel incontinence. Per review of the Minimum Data Set (MDS) annual assessment of 2/28/12, the Resident's diagnosis and conditions included ESRD (End Stage Renal Disease), diabetes, CHF (congestive heart failure), hypertension, anemia, osteoarthritis, recurrent urinary tract infections, recurring open areas on the buttocks and history of pressure sores. The Resident is dependent on staff for mobility, including transfers and assistance with repositioning. The Resident utilizes a motorized wheel chair for locomotion. The Resident is dependent on staff assistance for activities of daily living (ADLs) except for eating. During interview on 5/8/12 at 2:55 P.M., the Resident showed the surveyor the dialysis access, which was a tunneled central venous catheter (CVC) in the right chest area. The Resident stated that s/he has had a CVC for 2 years. The Resident also stated that s/he had 'sores' on the buttock area and required staff assistance for turning and repositioning in bed. The Resident also had a Foley urinary catheter. When the Foley bag was observed on the opposite side of the bed, the urine storage bag was laying directly on the floor. The Resident stated that Licensed Nursing Assistants (LNAs)	F 309	Care plans of all residents receiving dialysis or who have bowel incontinence will be reviewed for accurate assessments or appropriate care plans. Any resident with a Foley catheter has the potential to be affected by this alleged deficient practice. Nursing staff will be reeducated on proper procedure for positioning of the drainage bag. Catheter bag placement will be audited weekly x 30 days. Licensed nurses will be reeducated on the specific care of the CVC and emergency care and contacts. The resident care plan has been updated to reflect correct information and appropriate intervention related to the use of the CVC. An update will be brought to the QI Committee monthly x 3 months. DNS or designee will be responsible for compliance.	

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F 309	Continued From page 13 don't seem to be able to attach it to the bed/frame without it pulling uncomfortably. (It was noted that a clip to attach the tubing to the bed/frame was present on the catheter tubing). Further record review revealed that a urinary and bowel incontinence assessment of 4/2/12 stated that the Resident was incontinent of stool 1 - 3 times weekly, had redness in the buttock area and serious predisposing issues. The assessment was incompletely filled out, with no final scoring completed at the end. The Resident was receiving outpatient dialysis treatments 3 times weekly. The Resident stated on 5/8/12 at 3:00 P.M., that s/he does have a communication book which is used for written communication between the dialysis unit and the nursing home. During interview on the morning of 5/9/12, both the Licensed Practical Nurse (LPN) Unit Manager and the Registered Dietician (RD) confirmed that the Resident receives weekly data from dialysis but there was a lack of evidence of this information in the medical record. Awareness of the Resident's lab data is helpful to evaluate the dietary needs/adequacy for all staff caring for dialysis patients. Although the RD stated that s/he reviews this data via email, s/he confirmed that s/he does not usually put copies in the medical record. The RD communication from dialysis dated 4/6/12 stated that the Resident had high fluid gains and said "try to encourage pt" and relayed specific dietary recommendations. There was no evidence of these specific recommendations on the most current dietary care plan, dated 4/11/12. The care plan for nutrition did not have any individualized goals related to specific dialysis concerns (i.e. protein,	F 309	Completion date June 9, 2012. F309 POC accepted 6/14/12 TMynhier RN | RNcotaRN	

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F 309	Continued From page 14 phosphorous and calcium levels). The Resident's lack of desire to eat animal foods high in protein was not noted. Regarding nursing assessment, there was no evidence in the medical record that the unit nurse manager had completed an assessment of the Resident 's needs regarding the CVC for dialysis access. The use of a CVC required specific care and education for all staff providing care to the Resident because of the high potential for serious infection. Per review of the nursing care plan for Alteration in Health Maintenance: ESRD, the plan is inaccurate in multiple areas. The care plan stated - "Monitor shunt site for redness....treatment to shunt as ordered. SEE TAR...if bleeding occurs, apply pressure etc...Report to MD and dialysis if bruit and thrill are absent.." Although the Resident has 2 fistula sites, they are non functioning and the Resident receives dialysis through the CVC. Per a progress note from a hospital stay in October, 2011, the CVC was changed at that time and has remained in place since. During interview with the Unit Manager on 5/8/12 at 4:25 PM, s/he confirmed that s/he was not previously aware of the type of access device being used for dialysis until the surveyor brought it to his/her attention, that the care plan was inaccurate in multiple areas, that the care plan lacked any individualized interventions related to the use of the CVC or that there was no evidence of education for nursing staff and caregivers regarding care needs related to monitoring or emergency contacts for potential emergencies related to the CVC. The Unit Manager also confirmed that s/he was	F 309		

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F 309	Continued From page 15 not aware of the reason for the Resident's bowel incontinence and had not completed any assessment of the bowel incontinence. Although the care plan stated that the Resident had bowel incontinence, there was no goal related to the incontinence nor any interventions to decrease episodes of incontinence. In summary, the facility failed to accurately assess and provide care/care planning in accordance with Resident # 87's specific needs regarding dialysis and bowel incontinence. Refer also to F 272 and F 279.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to assure that a resident who had an indwelling catheter had a clinical condition/diagnosis for use, an assessment of the continuing need for use and received appropriate care to prevent urinary tract infections for one of three residents in the	F 315	F315 **No Residents were harmed by this alleged deficiency.** All staff will be reeducated on proper positioning on a Foley drainage bag. This will be evident by observation and education. Tubing will be clipped to bed to endure unnecessary pulling. Drainage bags will hang below the bladder and attached to the bed. Any resident with a catheter has the potential to be affected by this alleged deficient practice.	

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F 315	Continued From page 16 targeted sample utilizing urinary catheters. (Resident #87) Findings include: Per observation on 5/8/12 at 3:07 P.M., Resident #87's Foley catheter drainage bag was observed lying directly on the floor next to the bed in his/her room. The Resident stated that the LNAs (licensed nursing assistants) don't know how to clip the tubing to the bed so that it doesn't pull. There was an empty catheter bag holder observed attached to the bed frame during the observation. Per record review, the Resident has had recurrent urinary tract infections, has bowel incontinence and there was no reason specified for the continuing use of the Foley catheter. A urinary assessment dated 4/2/12, documented." incont. stool 1-3 times per week, has redness in buttock area, serious predisposing issues..". The assessment was incomplete and had no score or summary statement of conclusion. A progress note dated 6/27/11 by the Nurse Practitioner (NP) stated "Foley placed in the hospital- goal is to remove, keep in place until pressure ulcer heals-likely need bladder retraining." The Resident had ESRD (end stage renal disease) and the usual urine output per shift was 25 milliliters (ml) per interview with a LNA at 4 PM on 5/8/12. The care plan stated that the resident had chronic urinary retention, but there was no diagnosis found in the medical record. During interview at 4:25 P.M., the Unit Manager was not aware of the NP note regarding the Foley and possible bladder retraining. S/he was also not aware of any diagnosis indicating the necessity of the use of a Foley and confirmed that s/he had not completed a thorough assessment of the	F 315	Foleys will be covered for privacy. Catheter bag placement will be audited weekly x 30 days. An update will be brought to the QI Committee monthly x 3 months. DNS or designee will be responsible for compliance. Completion date of June 9, 2012. F315 POC accepted 6/14/12 TMynhierRN | AMcotaRN	

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F 315	Continued From page 17 bladder function. Refer also to F272 and F279.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and closed record review, the facility failed to assure that 1 applicable resident with a history of multiple falls received care and treatments to prevent accidents and failed to provide appropriate post fall care. (Resident #49) Findings include: Per record review on 5/9/12, Resident #49 sustained 4 falls during the period from 1/31/12 - 2/2/12 and exhibited a significant change in medical symptoms and staff failed to conduct thorough assessments and discharged the Resident to another long term care facility without assuring that the Resident's condition was stable. The Resident had a history of chronic leg pain (neuropathic) and was dialyzed 3 times weekly and was often noted to be tired and lethargic after return from dialysis. A progress note dated 2/2/12 at 0845 stated "nurse took over medication care at 0650 and was notified in report that pt. had fallen out of bed at 0600....pt... awake most	F 323	F 323 **No Residents were harmed by this alleged deficient practice.** Resident #49 no longer resides in the center. Any residents who falls will have the potential to be affected by this alleged deficient practice. Any resident who falls has the potential to be affected by this alleged deficient practice. Nurses will be reeducated in the policy and procedure for resident falls, including MD notification, neuro vital sign assessments, care plans updates and completion of incident report.	

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F 323	Continued From page 18 of night and may be sleepy. Pt....difficult to arouse, pupil response was sluggish, right hand grasp slightly greater than left, patient could not follow command to move legs, patient gave minimal response to sternal rub. This nurse attempted to asses vital signs and could not obtain B/P (blood pressure) reading from automatic cuff in left wrist.... Unit Manager able to obtain B/P in left arm using manual cuff. Vital signs were assessed two times on neurological assessment form, at 0705 and 0720, before patient left to be transferred to new facility. Patient vomited one time. clear liquid emesis, this was not alarming as this manifestation was consistent with 24 hour "bug" that has affected staff and residents over past 2 weeks." The nurse author of this note was interviewed on 5/9/12 at 2:00 P.M., and s/he confirmed that s/he did not notify the physician of the change in symptoms and multiple falls prior to discharge at approximately 8:45 A.M. Although a staff member accompanied the Resident on the van ride (a 2+ hour ride) to the new facility, the nurse could not be sure that the Resident was not exhibiting symptoms of significant head or other injury just prior to discharge. There was no other evidence in the medical record regarding gastrointestinal symptoms. Interview with the DNS and the RN for Corporate Compliance on 5/9/12 at 2:30 P.M., indicated that staff should have followed the facility's Neurological Assessment Flowsheet after these unwitnessed falls. The Flowsheet specifies NVS (neurovital signs) are to be done at the following frequencies: Q 15 minutes X 1 hour, Q 30 minutes X 4 hours, Q 1 hour X 2 hours and Qshift	F 323	All falls will be audited at concurrent review for compliance with policy and procedure. An update will be brought to the QI Committee monthly x 3 months. DNS or designee will be responsible for compliance. Completion date: June 9, 2012 F323 POC accepted 6/14/12 TMynhierRN | QMcoturN	

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F 323	Continued From page 19 X 72 hours. Per review of the NVS Flowsheets started on 1/31/12 at 0145, NVS were completed as required until 0730, when the Resident had another unwitnessed fall. Nurses failed to re-start the NVS and continued on the previous schedule. The Resident had another unwitnessed fall at 2015 on 2/1/12 and a nurse documented that "Neuro assessments continued to be implemented". However, review of the Flowsheet documentation revealed only a 3-11 shift note; staff failed to restart NVS again. The next NVS note was documented as an 11-7 note only. During interview at 2:45 P.M. on 5/9/12, the Unit Manager, confirmed there was a lack of continuation of the neuro vital sign assessments after the first fall and a failure to notify the physician of the significant change in symptoms. There was no incident report describing the fall of 2/1/12 at 2015 nor the fall on 2/2/12 at 0600. There was no evidence of a review of the care plan after the initial fall on 1/31/12, nor after subsequent falls. Per interview with the Unit Manager and the RN, after a fall staff should complete an incident report, then complete a fall assessment and review the care plan to determine if any new interventions are needed. At 2:20 P.M., the DNS agreed staff failed to complete required NVS and take appropriate actions (per facility policy/procedures) after the unwitnessed falls. Refer also to F157.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	Continued From page 20 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's drug regimen was free from unnecessary medications for one of 10 residents in the applicable sample. (Resident #119) Findings include: Per record review on 5/9/12, the MAR (medication administration record) for Resident #119 documented administration of an as needed (PRN) dose of acetaminophen by initialing the box on 5/8/12. However, the nurse failed to document the dose, time and reason for giving	F 329	F 329 **No Residents were harmed by this alleged deficient practice.** Resident #119 were not affected by this alleged deficient practice. Any resident requiring prn medication has the potential to be affected by the alleged deficient practice. Nurses will be reeducated regarding documentation of prn medication. Medication administration records will be randomly audited for compliance x 60 days. Audits will be reported to the QI Committee monthly x 3 months. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F329 POC accepted 6/14/12 TMynhier RN/ DMcotaRN	

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F 329	Continued From page 21 the medication and the response or effect on the back of the MAR, per the facility policy. The medication was ordered to be given for HA (headache) or fever over 101 degrees Fahrenheit. Per review of the pain assessment sheet for 5/8/12, at 2345 hours (on 7A - 7P shift), the nurse documented the Resident "denied pain" and there was no other documentation of a pain assessment for that date. The lack of documentation for the medication dose, time and reason given was confirmed with the unit manager at 11 A.M. on 5/9/12.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROWAN COURT HEALTH & REHAB	378 PROSPECT STREET BARRE, VT 05641

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F 431	Continued From page 22 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to assure that all drugs and biologicals were stored at proper temperatures for one of two resident units of the home. (Wing 1) Findings include: Per observations of the Wing 1 medication refrigerator temperature logs on 5/9/12 at 2:55 P.M., (with the unit manager), the logs for May, 2012 indicated that on May 2, 2012, the medication refrigerator temperature was 30 degrees Fahrenheit (F). This is below freezing and below the required temperature ranges for storage of insulin and other types of vaccines/medications. During interview on 5/9/12 at 3:00 P.M., the Director of Maintenance stated that he had not been notified of the out of range temperatures on May 2, 2012. During a review of the types of medications stored in the refrigerator with the LPN staff nurse moments later, 15 vials of insulin were observed and 1 vial of Tuberculin PPD (purified protein derivative), which was not dated when opened. The temperature at that time was 40 degrees. The lack of action taken for the out of range refrigerator temperature	F 431	F 431 **No Residents were harmed by this alleged deficient practice.** Residents have the potential to be affected by this alleged deficient practice. practice. practice. Unit Manager or designee will ensure that temp control logs are within proper temp parameters. All vials are dated when opened and expiration dates are on vials. Temp adjustments will be made immediately if out of range. Audits will be reported to the QI Committee monthly x 3 months. Random audits will be done weekly x 60 days. DNS or designee will be responsible for compliance. Completion date June 9, 2012. F431 POC accepted 6/14/12 TMynhierRN/ PMeotaRN	

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F 431	Continued From page 23 documented on 5/2/12 was confirmed with the Director of Nurses (DNS) at 3:05 P.M. During interview at 3:00 P.M., the unit manager confirmed she had not reviewed the refrigerator logs for May and was not aware of the out of range temperatures.	F 431		